2017 Review of Medicaid Transformation Legislation

The 2015 Medicaid Transformation legislation directs a shift in the Medicaid and Health Choice delivery system from one that is mostly fee-for-service to one that is mostly managed care. (S.L. 2015-245, amended by S.L. 2016-121)

- **Key Components:**

Prepaid Health Plans (PHPs)	PHPs will receive a **capitated** (per enrollee, per month) **payment** to cover all services to the enrollee. PHPs may be **commercial plans** or **provider-led entities** (PLEs) (defined in the legislation). Commercial plans may only operate statewide contracts, and PLEs may operate statewide or regionally. **3 statewide contracts** are required and up to **12 regional PLE contracts** are permitted.
Populations to be Covered	**All** populations **except**: dual eligibles, medically needy, presumptive eligibles, HIPP enrollees, and emergency-only recipients. Participation by members of a federally-recognized tribe is voluntary.
Services to be Covered	**All** services **except**: behavioral health services covered by LME/MCOs (for four years after the date capitated contracts begin), dental, PACE, certain services provided in school pursuant to an IEP, CDSA services, and services provided prior to an eligibility determination.
1115 Demonstration Waiver	Generally, demonstration waivers are approved for **5 years** and have a cap on the total amount of federal financial participation (FFP) that is available to operate the waiver. The cap on FFP is based on projections of what the State would spend to operate Medicaid without the waiver.

- **Timeline:**